State of Nevada
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Purchasing Division
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SUBJECT: Amendment No. 2 to Request for Information # ME79

DATE OF AMENDMENT: March 15, 2010

DATE OF RFI RELEASE: February 11, 2010

DEADLINE FOR SUBMISSION: April 5, 2010 @ 2:00 p.m. PDT

AGENCY CONTACT: Jennifer Benedict, Management Analyst II

The following shall be a part of RFI No. ME79 for the Medical Home Collaborative. If a vendor has already returned a response and any of the information provided below changes that response, please submit the changes along with this amendment. You need not re-submit an entire response prior to the RFI closing date and time.

Responses to Questions to DHCFP RFI # ME79

1. Is DHCFP interested in statewide or regional Medical Home programs? Would DHCFP be interested in pilot programs that reflect the unique geographic regions of the state?

   DHCFP Response: DHCFP is interested in both statewide and regional medical home programs. To contain initial costs and determine the success of the program, DHCFP would probably want to start in the urban areas of Clark and/or Washoe counties. Nevertheless, DHCFP is interested in input on all possibilities, including those that reflect the unique geographic regions of the State.

2. Is DHCFP interested in programs targeting adults and/or children? Are there children that would be included in the Level III population? Which populations are DHCFP most interested in including in the medical home (i.e., Medicaid Only, Dual Eligible's, etc.)? It is noted that long term care services are not within the scope of the medical home program, but there nursing home-certifiable populations (individuals residing in the community) that may be included?

   DHCFP Response: DHCFP is interested in programs targeting both adults and children. DHCFP wants to focus on any Medicaid recipient who would most benefit from a medical home program. This would be based on their claims data and/or diagnoses. Individuals still residing in the community would generally benefit from a medical home program.

3. What data (demographic, medical care utilization, etc.) is available publicly on the Level III population? Where can that be found?

   DHCFP Response: Information on Nevada Medicaid's fee-for-service population can be found at http://dhcfp.state.nv.us/managed.htm and click on the "RFI #ME79 Enrollment Data" documents and the "Disease Management Diagnosis Report" at the bottom of the page.

4. The cover page of the RFI notes that "this document must be submitted in the vendor's response." Do you mean just the cover page or do you want responses inserted into complete RFI document and submitted in that way?

   DHCFP Response: DHCFP requests that responders include both the cover sheet and the questions from the section(s) that the responder answered. The rest of the document does not need to be submitted.

5. **Section 1, Page 4, Scope of Work.** Please confirm that the PMPM quoted on page 4 under DHCFP PCCM program is accurate. Will DHCFP provide additional clarification of what services and functions are incorporated in the $30 – 140 figure?

   DHCFP Response: DHCFP confirms that the PMPM quoted on page 4 is accurate. However, this program was limited to a small group of providers and is no longer in operation. PCCM providers were required to perform case management services to their patients who were enrolled in the program. The breakdown of the rates on January 1, 1997, was as follows:

Tier	*Washoe*	*Clark*
65 and over - institutionalized	*$121.96*	*$140.49*
65 and over – in community	*$69.16*	*$83.75*
Under 1 year of age	*$50.61*	*$64.09*
1 to 14 years of age	*$31.91*	*$31.53*
18 to 64 years of age	*$81.85*	*$87.23*

6. **Section 1, Page 10. Multi Payer Collaborative**. Will DHCFP please provide more detail on the intended design of the "Multi-payer Collaborative" option? As currently described, it appears that this option would incorporate the Medicaid enrollees into a broader pool of enrollees covered under commercial group contracts which would limit participation in the program to insurers that currently have a significant commercial enrollment in the state.

DHCFP Response: The intent of a Multi-Payer Collaborative is to develop common definitions and expectations among a variety of payers to encourage providers to participate in a medical home program, thus leading to improved health outcomes and a reduction in overall health expenditures. It would be difficult to entice providers to participate in a medical home program if only a handful of their patients were eligible to participate. Implementing a medical home into a practice generally requires time, resources, and staff; therefore, the incentive needs to be significant enough for providers to participate. If a large percentage of a provider's caseload was eligible for a medical home program, then they would be more likely to devote resources to modify their practices to address the expectations of these payers.

Medicaid recipients would not be part of a broader pool, as DHCFP and any our applicable vendors would continue to manage the Medicaid insurance program and maintain individual contracts with providers. One of the Collaborative's roles would be to try to recruit a broad range of payers to participate in the larger medical home program; thus, participation would not necessarily be limited to insurers that have a significant commercial enrollment in the state. Any Nevada payer could theoretically choose to participate if they wanted to integrate a medical home program into their own provider contracts.

7. **Section 2, Page 10, Scope of Work**. Please confirm that the initial service area of PC-MH pilot is two counties in Nevada (Clark and Washoe)? If yes, what are the plans and timing to expand program statewide if the initial program is successful? If no, what is the initial service area for PC-MH pilot?

   DHCFP Response: Please see response to Question #1.

8. **Section 2.2 Page 16, Questions for Care Coordination Vendor**. Will DHCFP describe expectations with regard to timely data sharing among the State, the Medical Home and the Care Coordination vendor? As described, we believe that assuring access to timely enrollment, claims data and other utilization information will be essential to facilitating care management of the population. Will the State define the frequency of providing data as well as the elements that will be included for Care Coordination Vendors?

DHCFP Response: DHCFP agrees that access to timely enrollment, claims data, and other utilization information is an important component in facilitating care management. The frequency and method of providing data would need to be determined when DHCFP identifies the type of medical home program the State will be implementing. It would also need to be agreed upon between the chosen vendor and DHCFP if and when a Request for Proposal (RFP) is released and a contract has been awarded.

9. **Section 2.2, Page 17, Questions for Care Coordination Vendor.** Question 13 states, "Some concern has been expressed regarding standard approaches to care that either do not work or are too limiting." Will DHCFP please provide additional information regarding the concerns referenced in this question and give specific examples of the issue referenced?

DHCFP Response: There are a variety of concerns about different medical home models. For example, some states do not like the "Joint Principles of a Patient Centered Medical Home" definition of a medical home, as they say that the definition is too narrow and needs to include other providers, like mental health specialists. There is also some concern that the NCQA Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) tool focuses too much on health information technology, which is costly and does not sufficiently account for improving care or outcomes. These states believe that a practice could hypothetically score well on the NCQA tool by focusing on the technological aspects of care without providing better care or clinical outcomes.

Another challenge is centered on ensuring that an individual patient's needs are being met by their provider, as a standardized approach to care might not work for every patient. Creating a standardized system of care should allow some provider flexibility to allow them to address the unique needs of their patients.

10. **Section 2.2, Page 17, Questions for Care Coordination Vendor.** Will DHCFP provide a data book providing population demographics, utilization detail and break down of projected dual diagnoses for respondents to consider in developing recommendations for the State? Additional detail will give respondents a better picture of the population to be served through the Medical Homes Collaborative model and will inform respondents understanding of the potential barriers and proposed solutions.

    DHCFP Response: Please see the response to question # 3. DHCFP is requesting vendors responding to the Nevada MMIS Takeover RFP No. 1824 to propose mechanisms for identifying recipients and/or diagnoses that the vendor should focus on to improve health outcomes and reduce expenditures. Vendors could also be asked to identify these recipients in future medical home RFPs.

11. **Section 2.2, Page 18, Questions for Care Coordination Vendor.** Please define "realistically achievable" as referenced in Question 17.

    DHCFP Response: DHCFP is seeking information on what additional duties a medical home provider could be expected to perform. Are there certain things that would be too costly or take up too much time for a provider to do in his daily activities? Are there other activities that would be an effective and achievable medical home task that a provider could perform as part of his practice?

ALL ELSE REMAINS THE SAME.

DHCFP requests that responders sign and return this amendment with proposal submitted.

NAME OF VENDOR _____

AUTHORIZED SIGNATURE _____

TITLE _____ DATE _____